Commonwealth of Kentucky
Personnel Cabinet
Office of Public Employee Health Insurance

Dependent DROP Form

This form must be used for any qualifying event (QE) that allows you to DROP dependents from your plan. You must complete a Health Insurance Application to request other coverage elections such as moving out of service area.

Applicant's SSN ☐☐☐-☐☐-☐☐☐☐

Retiree's SSN (if applicable) ☐☐☐-☐☐-☐☐☐☐

Company Number ☐☐☐☐☐

Name (First, MI, Last) **(PRINT)** _____ Date of Birth (MM/DD/YYYY) _____

To be eligible to DROP a dependent from your health insurance plan, you must certify that you have experienced the QE as listed below. By signing this form you are also certifying that you are not under any court order or admnistrative order to cover the dependent(s) on your health insurance plan.

The QEs listed on this form are the only events that allow you to DROP dependents from your plan. **(Check One)**

- ☐ Marriage
- ☐ Divorce*/Legal Separation*/Annulment*
- ☐ Sp/Dep/Retiree's Death
- ☐ Administrative Order* or Court Order*
- ☐ Dependent child becomes ineligible
- ☐ Sp/Dep gains employer-sponsored group coverage
- ☐ Sp/Dep ends LWOP
- ☐ Ee/Sp/Dep becomes eligible for Medicare*
- ☐ Ee/Sp/Dep becomes eligible for Medicaid*
- ☐ Sp/Retiree has different open enrollment period
- ☐ Significant cost increase (*Dependent Care changes ONLY*)
- ☐ Other: _____

Qualifying Event Date (MM/DD/YY): _____

Note: Ee = Employee Sp = Spouse Dep = Dependent

** Supporting documentation is required.*

PRINT the following information for each dependent to be dropped:

Social Security Number	Name (First, MI, Last)	Relationship Code **

** Relationship Code: SP=Spouse CH=Child DD=Disabled Dependent CO=Court Ordered Dependent

Applicable to employees of State Agencies ONLY (Commonwealth Choice). All other employees must contact their Insurance Coordinator for specific information about the employer's Flexible Spending Account Program. Retirees are not eligible to participate in an FSA.

Healthcare Spending Account

I request a change in my "per check" deduction

from $_____ to $_____ employee money

from $_____ to $_____ employer money

Dependent Care Account

I request a change in my "per check" deduction

from $_____ to $_____ employee money

My signature below certifies that I understand the statements on this form and that all the information provided by me is true and complete to the best of my knowledge. I understand that any person who knowingly and with intent to defraud any insurance company or other person, files this form containing any materially false information or conceals, with the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. I understand that any material misrepresentation or material omission contained herein may be used to void this contract.

_____ Applicant Signature _____ Date _____ Insurance Coordinator Signature _____ Date

_____ Retiree Signature _____ Date

The following signatures are REQUIRED if changes to a cross reference plan are being requested.

_____ Spouse Signature _____ Date _____ Spouse's Insurance Coordinator Signature _____ Date